I know that we have other things to get to tonight, and certainly the AIDS issue is super-important.

Mr. Speaker, I do want to say in conclusion, these health care issues, we as Democrats are going to continue to bring up frequently over the next few weeks because we do want to see action, and we are not seeing it on the part of the Republican leadership or the President.

TAX CUTS AND PATIENTS' BILL OF RIGHTS

The SPEAKER pro tempore (Mr. ISSA). Under the Speaker's announced policy of January 3, 2001, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, I want to talk a little bit tonight about two issues: first, about the tax cuts that passed the House and the Senate just before Memorial Day recess; then I will talk a little bit about the patients' bill of rights.

Mr. Speaker, I remember in early 2000, it was before the Iowa caucuses, it was cold, I remember, and I was traveling around the State of Iowa, my home State, with then-Governor Bush.

We had spent the morning together, and then returned to Des Moines where he was going to address the Des Moines Chamber of Commerce and give a major address on cutting taxes.

So Governor Bush asked me if I would sit in and listen to him give his speech in preparation. There was just myself and one staffer. We were at the Marriott Hotel in Des Moines, and they had the rest of the doors closed off. Then-Governor Bush practiced his speech. I sat there listening to at that time Governor Bush lay out his tax cut plan.

Afterwards the Governor invited me upstairs and we had a hamburger together, just the two of us. Then-Governor Bush asked me, Well, what do you think? Well, we had been through here in the House a major tax cut bill not too long before that. It was in the range of about $790 billion, and President Clinton had promised a veto of that bill. In addition, we were doing that tax cut not in the context of a budget plan, and certainly not in the context of how much we were going to reduce the national debt.

Once President Clinton declared that he was going to veto that tax cut, then it gave free rein to every Member of this House and the other body to add every piece of special-interest tax cut legislation they could to that bill. It became what we would call here in Washington a Christmas tree on which Members could hang every little piece of special-interest ornamentation, with the full realization that in the end there would be no harm because the President said he was going to veto that bill.

Mr. Speaker, sure enough, the final project, the bill, it was full of special-interest provisions. And so in the light of that, when then-Governor Bush asked me over our cheese burgers what I thought of his bill, I said, I think it holds together. You do it in the context of reducing some debt, providing for some educational funding, and it will be okay. But my one piece of advice would be keep it free of all of those special-interest perks and special-interest items that got added to the last bill we dealt with. Focus on eliminating the marriage penalty tax. Focus on killing the death tax. Focus on reducing rates and make it a progressive cut. And if you handle that, if that is what the bill is, and it does not have all of these special-interest perks, then I think the American public is going to be happy with it.

Then-Governor Bush said I assure you, I will do everything in my power if I am elected President to make sure that we do not load that bill up with a bunch of special-interest provisions that expand that Tax Code out, little pieces of tax legislation that act for individual families or individual businesses. We will work to keep that out and keep it clean. You know what, Mr. Speaker, that is what we did.

Now, I would be the first to admit that I have not read every single line of that tax cut. To be quite frank, unless you have the whole Tax Code with you and can reference things, it is difficult to read and understand what every single sentence means. But I do know that a whole bunch of people have been looking at that tax cut, the one that we just passed, and the one that this week the President in a Rose Garden signing ceremony is going to sign into law.

There was a report in the New York Times just a few days ago that said they could only find one item that was a special-interest item in the Tax Code, and that was a repeal of a prior special-interest item for JC Penney. So the only thing that I am aware of that anyone has found that was a special-interest piece of legislation in this was a repeal of a prior piece of special-interest tax legislation.

I think, Mr. Speaker, that is a remarkable accomplishment. I think it is remarkable the leadership the President showed on this issue. This is a victory for him; but more importantly, it is a victory for the American taxpayer because clearly with the amount of surplus that we have projected, surplus taxes, it is reasonable to return some of that to the American people; and it is reasonable to fix certain inequities in the Tax Code.

It is unfair that for a couple who is living together but not legally married, that when they decide to formalize that relationship and they get married, that they should end up paying more taxes than if they just filed separately. We fixed that in this bill.

I have hundreds if not thousands of small businesses in my district, which is Des Moines, Iowa, and southwest Iowa, that are going to benefit from the provisions on killing the death tax.

There are thousands of people in Iowa, and I think millions in the United States, that when you add in the fact that we are reducing the bottom rate from 15 percent to 10 percent, that we are doubling the child tax credit, that we are allowing for increased deductibility in pensions, they will find that they are not going to pay any Federal taxes, and they are also going to get a rebate this year; and I think that is good for the economy, too.

Mr. Speaker, I am looking forward to that Rose Garden signing ceremony, and I am also looking forward to flying back to Iowa with President Bush to hold a rally on exactly this tax cut. I think it is really important to my State and to the country. I think it is important because it helps restore consumer confidence. It will get some funds, needed funds, back into people's pockets and it sets up tax reductions that people can make plans, financial plans on for the next 10 years.

Mr. Speaker, I feel privileged that I was able to participate in a very small sense with the President when he was running for the Presidency, and on the very day that he gave his tax cut talk. And I feel privileged also that I will be able to spend this coming Friday with the President when he returns to my home State to talk a little more about this tax cut.

□ 2015

Mr. Speaker, I want to talk a little bit about the need for a patients' bill of rights. If you will remember, Mr. Speaker, a number of years ago, there were a whole bunch of jokes and cartoons about HMOs. If you look through a magazine like The New Yorker today or other magazines or even watch some of the late night shows, you rarely see or hear HMO jokes anymore.

I remember a few years ago when this joke was going around. There were many variations on it. You had three people who died and went up to heaven and they were waiting at the pearly gates. One was a nurse, one was a doctor and one was an HMO reviewer.

St. Peter asked the nurse, ''Well, what did you do in order to gain access to heaven and pass the pearly gates?''

She said, ''I took care of patients for 40 years. I counseled their families. I gave them all the loving care I could.''

St. Peter said, ''Enter.''

Then he asked the doctor, a neurosurgeon, ''What do you think you did to deserve entry into heaven?''

She said, ''I got up in the middle of the night and I took care of some of the most horrific head injuries, frequently never got paid because many times those poor victims never had any insurance, but I didn't care because it

was my Hippocratic oath duty to take care of those people who were injured.''

St. Peter said to her, ''Enter the pearly gates.''

He asked the HMO manager, ''And what did you do to merit entry into heaven?''

The HMO manager said, ''I managed to save the company millions and millions of dollars by denying care. So it really helped the stockholders.''

St. Peter looked at that person for a little bit and said, ''Enter, but only for 3 days.''

Now, that joke has had a lot of permutations, it is an old joke, probably most people have heard it, it is not even that funny anymore, because you knew the punch line.

Remember when Helen Hunt in the movie As Good As It Gets appeared with Jack Nicholson? She was talking about her son who had asthma and how her son was being denied necessary medical care. Then she went into a long string of expletives about that HMO. And I saw something happen I had never seen before. My wife and I were at a theater in Des Moines and people actually stood up and applauded. I had never seen that before.

Mr. Speaker, that movie today would not get the same response, because in order for something to be sort of funny or humorous, there has to be maybe a little bit of an element of surprise or a twist, something that catches you by surprise. Anymore, Mr. Speaker, it is hard to do a joke about HMOs because nothing is surprising anymore about the abuses or the denials of care that we continue to see year after year.

Back then, Mr. Speaker, a few years ago, 4 years ago maybe, people were seeing headlines like this from the New York Post: ''HMO's Cruel Rules Leave Her Dying for the Doc She Needs.''

Or here was a headline from a few years ago in the New York Post: ''What His Parents Didn't Know About HMOs May Have Killed This Baby.''

So this was all very topical as these stories of HMO abuses became known to the public. Time Magazine had a cover story on this. It was topical. It was the type of thing that you would see in The New Yorker in a cartoon, because this was somewhat new, it was new material, and there was something of a surprise. You could put a twist on it.

I remember a few years ago when the story came out about an HMO requiring same-day discharge, the so-called drive-through deliveries. That surprised people. They thought, that is awful, that is outrageous. And so you saw a cartoon.

Here is the maternity hospital. You have got the drive-through window, ''Now Only 6-Minute Stays for New Moms.'' The hospital employee saying, ''Congratulations. Would you like fries with that?'' And you have got a mother, her hair all frazzled with the crying baby as they are driving the car through. Kind of funny but also not so funny. Today this would not be as funny and you would not see this so much, because it is not new. Everyone knows this.

Mr. Speaker, before I came to Congress, I was a reconstructive surgeon in Des Moines, Iowa. I took care of farmers who put their hands into machines. I took care of women who had breast cancer. I took care of a lot of children with cleft lips and palates and other craniofacial deformities that they were born with, like this baby here.

Mr. Speaker, in the last few years, more than 50 percent of the surgeons who take care of congentital deformities like this have had cases denied by HMOs because these are, quote, cosmetic cases. I think that is awful. But also, Mr. Speaker, I would say anymore it almost does not shock anyone to hear this, because people have known about this now for years. People are also wondering why Congress has not dealt with this for years.

This was a cartoon from a few years ago. Here we have a doctor in the operating room and we have the HMO bean counter next to him. The doctor says, ''Scalpel.'' The bean counter HMO member says, ''Pocket knife.'' The doctor says, ''Suture.'' The bean counter says, ''Band-Aid.'' The doctor says, ''Let's get him to intensive care.'' The HMO employee says, ''Call a cab.''

Another cartoon from a few years ago. ''Your best option is cremation, $359 fully insured.'' And the patient is saying, ''This is one of those HMO gag rules, isn't it, doctor?''

This was very topical a few years ago, because the news was that HMOs were telling doctors they could not tell a patient all of their treatment options without first getting an okay from them. In other words, I as a doctor could see a woman for a breast tumor, listen to her story, do an examination, but before I could sit down and tell her what her treatment options were, if I had a certain type of contract from an HMO, I would have to say, ''Excuse me,'' leave the room, get on the phone and ask the HMO if it was okay if I told that patient all of her treatment options. That is clearly wrong. It was clearly news. That news generated this type of response.

A few years ago, we did a full debate here on the floor of Congress on the Norwood-Dingell-Ganske bill and actually brought to the floor this particular patient. A number of years ago, a young mother had about a 6-month-old son who was really sick in the middle of the night. He had a fever of about 104. Mom did what she was supposed to do. She phoned the HMO 1–800 number, got a reviewer on the phone, said, ''My baby is really sick and needs to go to the emergency room. What should I do?'' The reviewer said, well, take him to such and such a hospital. Now, Mom and Dad lived clear on the south side of Atlanta, Georgia. The reviewer told them the name of a hospital. The mother said, ''Well, where is it?'' The reviewer said, ''Well, I don't know. Find a map.'' It turned out that the hospital was clear on the other side of metropolitan Atlanta. So Mom and Dad, not being medical professionals, wrapped up little James in a blanket, got him in the car in the middle of the night and started out for the designated hospital. In the process, they passed several emergency rooms, but they were not health care professionals, they were just average people without a medical background. They did not know exactly how sick he was, but they were following orders because they knew that if they had stopped at an emergency room that was not authorized, then the HMO would not pay for the hospitalization. They would be stuck maybe with thousands of dollars of bills. So they moved on.

Before they get there, the little baby had a cardiac arrest and stopped breathing. So imagine Dad driving frantically while Mom is trying to keep this little baby alive. They pull finally into the emergency room entrance. Mom leaps out of the car saying, ''Save my baby, save my baby,'' a nurse comes running out, they get the baby resuscitated, they start the IV lines, they start antibiotics and they manage to save this little baby's life.

But because of that HMO's medical judgment over the telephone when they never examined the baby, they made a medical judgment. The judgment was that baby is well enough to go 50 miles. Instead of saying, ''Take that baby to the nearest emergency room,'' they said, in essence, ''Our judgment is, it's all right, you can take him a long ways.'' That was the medical judgment. That medical judgment by that HMO resulted in this. Yes, we saved James' life; but because of that cardiac arrest and the delay in treatment, he developed gangrene in both hands and both feet and both hands and both feet had to be amputated.

This little boy is growing up to be a fine young man. He sat right in this chair right in front of me during the debate. He is able to pull on his leg prostheses, and he can walk okay. He needs help to get his bilateral hook prostheses on. Sometimes he uses them and sometimes he does not. But he will never be able to play basketball, he will never be able to touch the face of the woman he loves and marries with his hand. If he had a finger and you pricked it, he would bleed.

This little boy is not an anecdote. I hear a lot of opponents to the Patients' Bill of Rights saying, ''Oh, you're just talking about anecdotes. We shouldn't legislate around here on the basis of anecdotes.'' Those anecdotes are real live people, if they survive the HMO care. And a funny thing is that under a

Federal law that was passed 25 years ago, in situations like this where the insurance is from the employer, that health plan, that HMO, is liable, this is under a Federal law, is liable for nothing other than the cost of care denied, or in this situation the cost of his amputations. I would ask you something. I mean, is that justice? Does that set up a proper incentive for the HMO not to cut corners but to provide the necessary treatment right from the beginning so that you prevent cutting the corners so tight?

A judge reviewed this case. The judge said that this HMO's margin of safety was razor thin, quote-unquote. Razor thin. I would add to that as razor sharp as the scalpel that had to amputate little James' hands and his feet.

And so as cases like this became known to the public, they continued to spawn cartoons. Some of the cartoons were what I would say black humor. Let me give you an example. Here is a medical reviewer. Maybe it was the medical reviewer who was a thousand miles away for that little boy who I just showed you. The medical reviewer saying, ''Cuddly care HMO. How can I help you?'' The next one is, ''You're at the emergency room and your husband needs approval for treatment? Gasping, writhing, eyes rolled back in his head? Doesn't sound all that serious to me. Clutching his throat? Turning purple. Uh-huh.''

Down here. ''Well, have you tried an inhaler?'' The next one is, ''He's dead?'' And the next one is, ''Well, then he certainly doesn't need treatment, does he?''

And finally the last one in the corner says, ''People are always trying to rip us off.''

□ 2030

I guess this young lady must have been trying to rip off her HMO. She was hiking about 70 miles west of Washington, D.C., with her boyfriend. She fell off a 40-foot cliff. She had a fractured pelvis, a broken arm, a fractured skull. Luckily, her boyfriend had a cell phone.

He pulled it out. They called an emergency number, got a helicopter to fly in. Here she is. She is strapped into a gurney about ready to be taken onto the helicopter. She is taken to the emergency room. She is treated in the intensive care unit for a month or so. She is semicomatose. She is certainly on significant doses of pain medicine.

What does the HMO do? The HMO refuses to pay her bill. Why? Well, because she did not phone ahead for prior authorization.

Now think about that for a minute. Was this lady supposed to be so clairvoyant that she knew she was going to fall off a 40-foot cliff so that she could phone ahead and let the HMO know? I do not think so, but that was their excuse for not paying her bill.

So it is real life stories like that that would generate a cartoon like this. This is the HMO Claims Department. The reviewer is saying, no, we do not authorize that specialist; no, we do not cover that operation; no, we do not pay for that medication. Then apparently the reviewer hears something, shakes her head and then she says, no, we do not consider this assisted suicide.

Well, as I said earlier, these are not just anecdotes. This is a family that was featured on the cover of Time Magazine a few years ago. This woman had breast cancer. Her physician recommended a certain type of treatment. So she went to a major, well-known medical center in the country and they were going to do it. They agreed, until they got a phone call from the HMO saying we do not think you should do that; that is very expensive treatment, and we will evaluate whether we continue our contract with your medical center.

So she did not get all the information that she needed. She did not get her treatment and, at least according to what was thought to be appropriate medical care at that time, she did not get the appropriate medical care and she died. Today, her little boy and her daughter and her husband do not have this young mother. She did not have the type of appeals process to handle a denial of care that was very likely inappropriate, at least for that time.

We want to do something about that. That is one of the reasons why we need to pass at the Federal level a patient bill of rights.

Now I am going to go into some detail on the Ganske-Dingell bill here that will come up here in the House, and its companion bill, the McCain-Edwards bill in the Senate, but before I get into all the details and they get a little bit dry, I think it is important for me to do them, to share the details with my colleagues, if any are watching. I think it is also important just to briefly go over some of the major issues of contention.

Number one, the opponents to our legislation say well, this will drive up health care costs. Now this is sort of an interesting criticism in light of the fact that in the last few years, the HMOs have increased their premiums very significantly, and it was not because of any patient bill of rights. It was because their shareholders said they needed more profit, and it was also because the cost of prescription drugs is going up a lot. We have seen premium increases, significant ones, in the last few years and it sure was not because of Congress passing a patient bill of rights. So do not believe all of that sky-is-falling stuff.

What would the cost of our legislation be? The Congressional Budget Office scored our bill. It would cost a total of 4 percent over about 5 years, and the major items of cost are not the liability at all, but the dispute resolution on internal and external review. In fact, the liability provision that would return responsibility to the health plans, fix something that Congress took away from the States 25 years ago, would cost a total of about .9 percent; that is .9 percent, less than 1 percent cumulative over 5 years. That amounts to the cost of about one Big Mac meal per month per employee.

In fact, that has been very, very close to the cost of the patient protection bill in the State of Texas, which our bill is modeled after, and which President Bush, on many occasions during the campaign, bragged about as saying that that patient bill of rights down there in Texas has worked just fine, and it has. We wrote our bill based on that.

So do not believe the exaggerated, hyperinflated, sky-is-falling claims on costs. Look at the HMO's claims with a bit of a jaundiced eye, particularly in light of what they have been doing with their premiums on their own, primarily for stockholder value.

Another major issue is, well, if the health plans are liable where should that liability be? Because Congress basically 25 years ago said, you are not liable for any of your decisions other than the cost of care denied.

Well, what we want to do is we want to build on a Supreme Court decision that basically says if it is a matter of medical judgment, then it goes to the State where it has been for several hundred years.

As a physician, I am liable for any malpractice under State law. I believe that an HMO, which is making medical decisions, should have that same responsibility.

Now there will be some who will say, no, let us have all of that liability on the Federal side of the ledger, not at the State level. My response to that is, well, number one, it is not a very Republican, and that is with a capital ''R'' idea. I always thought my party stood for States' rights and having responsibility closer to the people.

Take somebody in certain parts of Iowa and require them to go to a Federal court, and a long trip has been added, and a lot of expense. The same thing would go for Michigan or Nevada or other places. There is also such a thing as the tenth amendment to the United States Constitution, and that says that unless the Constitution has specifically given a power to the Federal Government, then the power should reside at the State level.

We have had that responsibility. It has traditionally been the responsibility of States to regulate insurance. In fact, we have even passed laws here in Congress like the McCarran-Ferguson Act to that extent, and we think that it should be that way also.

If all that case law was moved to the Federal side, it would be a usurpation

and, I think, unconstitutional. It would also be something that the Federal judges are telling us do not do this. The Federal judges have seen some of these cases. They think that we should fix ERISA, the Federal law 25 years ago that took the jurisdiction from the States. They say move it back.

So when we look at this issue of Federal-versus-State jurisdiction, we need to look at a few questions: whether the proposed legislation is within the core functions of the Federal system; whether the Federal courts have the capacity to take on new business without additional resources or restructuring and the extent to which proposed legislation is likely to affect the caseload in the Federal courts; whether the Federal courts have the capacity to perform their core functions and fulfill their mandate for ''just, speedy and inexpensive determination of actions.''

I respect judges like Judge Pickering of Mississippi, the father of one of our colleagues, Congressman PICKERING. What Judge Pickering says is get this to the State level. That is where it belongs when you are talking about medical judgments. If you are talking about benefit decisions, then that is fine, leave it at the Federal level under ERISA so the plans can devise their own benefit packages, so that plans do not have to follow individual State mandates. But if you are talking about medical judgment decisions, it should be at the State level.

Here is what Judge Gorton in Turner versus Fallon Community Health Plan said in 1977:

Even more disturbing to this court is the failure of Congress to amend a statute, that due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent.

Here is what Judge Bennett said in Prudential Insurance versus National Park Medical Center:

If Congress wants the American citizens to have access to adequate health care, then Congress must accept its responsibility to define the scope of ERISA preemption and to enact legislation that will ensure every patient has access to that care.

Here is what Judge Garbis in Pomeroy versus Johns Hopkins said:

The present system of utilization review now in effect for most health care programs may warrant a reevaluation of ERISA by Congress so that its central purpose of protecting employees may be confirmed.

Here is the 1999 proposed long-range plan for the Federal courts. This is something that Chief Justice Rehnquist has been involved with. It says Congress should commit itself to conserving the Federal courts as a distinctive judicial forum of limited jurisdiction in our system of Federalism. Civil and criminal jurisdiction should be assigned to the Federal courts only to further clearly define and justify national interests, leaving to the State courts the responsibility for adjudicating all other matters.

In other words, do not give us an area of law that has traditionally, for 200-plus years, been at the State level.

In 1998, the year-end report of the Federal judiciary, Justice Rehnquist says this:

This principle was enunciated by Abraham Lincoln in the 19th century and Dwight Eisenhower in the 20th century. Matters that can be handled adequately by the State should be left to them. Matters that cannot be so handled should be undertaken by the Federal Government.

Why do the Federal judges not want this jurisdiction? Number one, it has never been in the Federal courts. It has always been in the States.

Number two, practically speaking, they do not think they can handle this. If one wants a speedy adjudication and a speedy determination to resolve a dispute, do not go to the Federal courts, believe me, particularly if they would like to avoid costly litigation, because it is lengthy and costly in the Federal courts and anyone who proposes moving all of this to the Federal courts is ignoring a fact in this country.

□ 2045

In the Federal courts, by the Speedy Trial Act of 1974 the Federal courts have to give priority to criminal cases. The criminal case filings were up 15 percent in 1998. This means that all of those drug cases that the Federal judges are charged to adjudicate come before anyone who has a problem on a civil case related to health care.

This was the situation in the Federal courts just a few years ago: they had 65 vacancies, 22 emergencies, 16 anticipated. It is more than that. We are going to have a big debate in the Senate about the appointment of Federal judges. But everyone agrees that the Federal bench is significantly understaffed, so the last thing that they need is for us to do something unconstitutional and move something that should reside at the State level. All of that.

I mean, are we in Congress going to rewrite all the statutes, the evidentiary rules on State tort and move it into the Federal courts? I know an awful lot of conservative Republican Congressmen who should have a lot of heartburn with that, because they know what certain Federal court jurisdictions which have been very liberal might do with this type of jurisdiction. It all goes to show, you had better be very, very careful what you ask for.

Mr. Speaker, in the remaining time that I have, I want to talk just a little bit about the bill itself, the Ganske-Dingell bill in the House, the McCain-Edwards bill in the Senate. This is not the same bill that we voted on in 1999. We made a good faith effort to come to some significant compromises with our opponents on this legislation. We used, for instance, exact language or modified language from a number of bills, including the opponents', the opposition bills, to try to meld a compromise on this piece of legislation.

There are some significant differences which I want to get into in some detail between the Ganske-Dingell bill and the Norwood-Dingell-Ganske bill that passed in 1999, but we still think this is a strong bill and a necessary bill.

With utilization review, we use language from the Norwood-Dingell bill. For prior authorization, we establish basic standards and time frames for the initial review of claims for benefits. We say that prior authorization determination should be made in a timely fashion according to the medical facts of the case. For normal cases, an insurer should respond within 14 days from the date the plan receives the information, but in no case later than 28 days. If an insurer requests information from a patient-provider, they have 5 days from the request to submit such information.

The bill ensures that requests for care are handled quickly. In instances where the insurer and the doctor disagree about a patient's treatment, the insurer must disclose the reason for the decision and inform the patient of the right to appeal that decision. You know what, Mr. Speaker? That language is adopted from the Nickles amendment in the Senate.

We then have a section on internal appeals, so that if a patient's doctor recommends a type of treatment, but then the health plan, the HMO, says, no, you have a certain procedure to go through in the plan to get a hearing, some due process. We used the language from the Nickles amendment there. This was a Republican Senator's amendment.

On external appeals, let us say that a patient is denied treatment they think is necessary and their doctor thinks is necessary. They go through an internal appeals process. The plan still continues to deny the care. Then we set up a way for the patient to go outside of the health plan to get an external review, an external appeal. We looked through all of the language, and we basically use language for our section 104 language that was adopted from the Nickles amendment.

In the access to care section, we say that the bill provides the right for individuals to elect a point of service option guaranteeing access to any doctor, regardless of whether or not that doctor is in the plan's network. But we say also that the patient would be responsible for the additional cost of that provision. In that instance we use language from the Norwood-Dingell bill.

But then we talk about emergency care. We say that the bill gives patients the right to go to the closest emergency room for an emergency room. Like that little boy. If this bill had been law, then those parents would

not have needed to phone that 1–800 number. If they had, they could have still known that instead of going so far, they could have just taken that sick little baby directly to an emergency room. For our bill, the Ganske-Dingell bill, we used language from the Goss-Coburn-Shadegg substitute that was debated on this floor.

We have a provision in there for access to specialty care, so that people can get access, can go to the appropriate specialist. We use language adopted from the Nickles amendment. We have a provision in this bill for access to obstetrical-gynecologic care and pediatric care, and we used language adopted from the Nickles amendment for that.

We have a provision on continuity of care. The bill would allow a patient who has an ongoing and serious medical problem to continue to see their provider, their doctor, for up to 90 days, in the event that that doctor is no longer with that health plan. We have specific protections for individuals who are pregnant or terminally ill or are scheduled to have surgery, and we use language adopted from the Nickles substitute for that.

We have access to non-formulary drugs. The bill provides a provision to allow doctors to prescribe a drug that is not on the health plan's, the HMO's formulary, when a non-formulary drug is medically necessary. That protection is very important for a lot of individuals who may have allergies to certain types of medications, who have tried the HMO's formulary drug, but have not had success; and we used language adopted from the Nickles amendment for that.

We have a provision that would allow access to clinical trials, so that patients would have greater access to certain clinical trials, patients with Parkinson's disease, Alzheimer's, cancer and other serious diseases that are life-threatening and for which no standard treatment is effective. Some in the consumer groups would like to see that provision expanded and made more broad, but we used language from the Norwood-Dingell bill for that.

We have a provision in the bill for women's health and for cancer protection, important provisions relating to women's health, that guarantee the women the right to have a doctor decide the appropriate length of stay, for a woman who has a mastectomy, for instance. Remember when the HMOs were saying gee, you can have your breasts removed as an outpatient? Well, I have done a lot of breast surgery, and I will tell you what, it is the rare patient that could tolerate that as an outpatient. Furthermore, it would be the very rare patient where I think that that would be safe. So we used language adopted from the Nickles amendment for that provision.

In fact, at least 50 percent of the language in our compromise bill is language from the Nickles amendment, the Republican Senate substitute that was debated 2 years ago. The same thing goes for access to information, information disclosure, language adopted from the Nickles amendment.

Now, one thing that we did keep from our bill was we have language to ensure that doctors are free to discuss all treatment options with their patients, and we used the language from the Norwood-Dingell-Ganske bill for that.

We have language that protects health care professionals from discrimination based on their license. We used language from the Nickles amendment.

We can go through a whole bunch of further issues, but I think it is important to talk about the liability provisions in the Ganske-Dingell bill and to share this, because there will be a lot of debate about this issue when this comes to the floor. This will come to the floor in the Senate either this week or next week, and I think it will probably come to the floor here in the House pretty soon thereafter.

Title III in the Ganske-Dingell bill applies standards to the Employee Income Retirement Security Act, ERISA. For self-insured health plans regulated by the Department of Labor, our bill would be both a floor and a ceiling. Let me explain that.

As under current law, States cannot place further regulations on ERISA-based health plans. A key attribute of ERISA is that it provides for a uniform set of rules for health benefit plans operating across several States. We think it should stay that way. Yet under current law, practicing health care professionals are subject to the varying laws of each specific state.

The new provisions of our bill strike a solid compromise, recognizing that employers should expect uniform rules for administrative processes, but that any ''medically reviewable decisions'' would be subject to State law, just as doctors are.

This new bifurcated Federal-State structure is a significant modification from the purely State cause of action that was in the original Norwood-Dingell-Ganske bill.

The original language did not change the current law remedy in section 502 of ERISA, but rather simply clarified that State causes of action were not preempted. The business and insurance community voiced concerns that this approach would inhibit their ability to administer a multi-State employee health benefit plan. By leaving suits involving benefit administration decisions in Federal court under section 502 in our current version in the Ganske-Dingell bill, employers and insurers will have relative uniformity for administering their health plans across State lines.

The first piece of the bill liability package adds to the existing Federal remedy under ERISA section 502. ERISA section 502 is amended to provide a cause of action in Federal court for a patient who has been injured or killed by a negligent denial of a claim for benefits that does not involve a medically reviewable decision.

Under this new Federal cause of action, a plaintiff may seek both economic and non-economic damages. By excluding medically reviewable decisions from the Federal remedy, group health plans will only be subject to liability under section 502 for benefit administration decisions that cause harm or death. Those include decisions such as whether an employee is eligible for coverage, whether a benefit is part of the plan or other purely administrative contractual decisions.

Punitive damages are not allowed under the Federal cause of action. A civil assessment may be awarded upon showing clear and convincing evidence that the plan acted in bad faith and with flagrant disregard. Those are high standards.

This standard carries a high burden of proof and is consistent with State statutes. This standard ensures that a health plan will not be subject to these damages for simply making a wrong decision. A plan must show flagrant disregard for the health and safety of others. Before exercising that legal remedy, the patient has to exhaust both internal and external appeals processes. If the patient suffers irreparable harm or death prior to the completion of the review process, the patient or heirs of the plan can elect to continue the review process and the court can consider the outcome. That is from language adopted from the Goss-Coburn-Shadegg substitute that was debated on this floor 2 years ago and which received a lot of support from the Republican Members.

The second piece of the bill liability package amends ERISA section 514 to allow causes of action in State court for a denial of a claim for benefits involving a medically reviewable decision that causes harm or death to a patient.

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Punitive damages are prohibited in cases where the plan properly followed the requirements of the appeal processes and followed the determination of an external review. However, as in the Federal cause of action, punitive damages are available in cases where there is a clear and convincing evidence that the plan exhibited a willful or wanton disregard for the rights and safety of others.

I want to ask my colleagues something: Do we want to vote for a bill that says if a plan exhibits willful or wanton disregard for the safety or rights of others that they should not have any responsibility? I mean, do any of my colleagues want to bring a

bill to the floor that would say that if a tire explodes and people are killed and that company that made that tire showed a willful and wanton disregard for the safety of the purchaser, that they should not be liable? Well, I do not know about my colleagues, but I sure do not want to go home and campaign with that on my record.

In our bill, before exercising this legal remedy, the patient has to exhaust both internal and external appeals. But if the patient suffers irreparable harm or death prior to the completion of the review process, either the patient or heirs or the plan can elect to continue the review process and the court can consider the outcome. But we do not want to pass a law that says that a plan can slow-walk an appeals process, delay treatment, make this thing go on and on, and then have the patient die in the meantime, and then be liable for nothing; at least I do not want to.

Now, the Norwood-Dingell bill removed the ERISA section 514 preemption of State law for all torts and allowed injured patients to bring a cause of action in State court for injuries caused by a medical decision or an administrative decision. Our new bill is different. Our new bill says, and it is a significant compromise, it limits the scope of actions that can be filed in State court to only those involving medically-reviewable decisions. That is a major compromise. We made this step towards the opponents to our bill.

This bifurcation of the remedy into a State component and a Federal component holds to the principles underlying ERISA. The existing Federal cause of action under ERISA affords health plans a set of uniform standards for making administrative decisions. That is what ERISA was intended to do. That is why it was originally designed to be a bill for the benefit of employees, not employers. However, when a health plan makes a decision that involves medical judgment, that plan, in my opinion, should be subject to the State laws, and recent Supreme Court decisions and the 5th Circuit decision upholding the Texas health plan liability would allow for the continued development of State laws.

Mr. Speaker, I will summarize here. There are a number of States that have passed health plan liability laws: Arizona, California, Georgia, Louisiana, Maine, Oklahoma, Tennessee, Texas, Washington. The Ganske-Dingell bill, the McCain-Edwards bill recognizes that. The bills that would move all liability into Federal courts would preempt those States. We provide a floor; they preempt.

Finally, let me just say a word about the employer protections, because we have a significant compromise in this bill from the last time around. The last time around we said an employer could be liable if they exercise discretion or authority; and the business community said, we think that that standard is a little loose, so we changed it. We use now a standard that was proposed by opponents to our bill last time that says, only if we directly participate can one be held liable.

Mr. Speaker, there are very few that do that. We have a big bill coming up for debate. I hope my friends and colleagues will look at this bill in detail.

AIDS EPIDEMIC

The SPEAKER pro tempore (Mr. ISSA). Under the Speaker's announced policy of January 3, 2001, the gentleman from Texas (Mr. RODRIGUEZ) is recognized for 60 minutes.

GENERAL LEAVE

Mr. RODRIGUEZ. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the Special Orders of today.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. RODRIGUEZ. Mr. Speaker, today we mark the 20th year of the AIDS epidemic. On June 5, 1981, the Centers for Disease Control published a morbidity and mortality weekly report on the diseases which affect AIDS. I spoke at the rally this past Sunday.

Mr. Speaker, I yield to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Speaker, I want to thank the gentleman for providing this hour for us to discuss this important issue and remember and look back over the 20 years since the first cases of then an unknown disease was being discovered.

The gentleman and I were fortunate today to be able to spend some time at a symposium in Washington that was sponsored by the Kaiser Family Foundation and the Ford Foundation to look back over those years to see how far we have come and how far we have yet to go. I want to take this opportunity to thank the Kaiser Foundation and the Ford Foundation for their work, the support that they provide to research, the support that they provide to community organizations and this country and around the world, to address this disease.

We also heard the gentlewoman from California (Ms. PELOSI) earlier talk about the people who preceded her and we mentioned today how fortunate we were as we came to Congress in 1997 to have the work of the gentlewoman from California (Ms. PELOSI), the work of the gentleman from Washington (Mr. MCDERMOTT), Lou Stokes, and the gentlewoman from California (Ms. WATERS), and many, many others to build upon.

We have really seen a lot of wonderful advances in the last 20 years, but we still have a lot more that has to be done. We have seen the identification of what was then an unknown disease to advanced therapies that have transformed what was a death sentence to now what is almost a chronic disease. We have an improved quality of life for those who have been diagnosed with HIV. They can live comfortable and quality lives rather than just having to wait to die.

Mr. Speaker, I am going to turn this Special Order back to the gentleman from Texas (Mr. RODRIGUEZ), and I will join him again later at the conclusion of his comments.

Mr. RODRIGUEZ. Mr. Speaker, let me thank the gentlewoman from the Virgin Islands. I know that from the Black Caucus the gentlewoman has been working diligently, and as chairman of the Hispanic Caucus on Health, I want to thank her specifically for the work that she has been doing on this issue and all issues on health, so I thank the gentlewoman. I look forward to continued dialogue.

Let me just make a few comments. We have other fellow colleagues that are here with us today, but I want to take the opportunity to just say that it is hard for me to believe that it has been 20 years, and as the sign back here says, ''Twenty Years is Enough.'' Twenty years later, HIV/AIDS has taken the lives of close to 22 million people worldwide. It is hard for me to also believe that 15 years ago, I was in the Texas legislature listening to my fellow colleague denounce the spending money on AIDS prevention because of narrow bigotry. In essence, he would say, these people deserve it. I only mention that because thank God that we have really come a long way from that perspective, and I am proud to stand here today and see how far we have come, although we have a lot more to do.

I would like to recognize the countless individuals and organizations that are out there working on issues such as research on AIDS trends that affects new drugs, the advocacy groups that are out there working, the advocacy groups that are working for children with AIDS, the foundation activities that are raising awareness in the area of AIDS, the key components and the global effort in the area of AIDS. The Hispanic Caucus, the Black Caucus and the Asian Pacific American Caucus are working together to find solutions to specific communities of color also. As chairman of the Congressional Hispanic Caucus Task Force on Health, I have had the opportunity to work with many of my friends and colleagues on efforts to increase resources for AIDS prevention, education, and treatment. It affects the lives of the rich, the poor, the famous, the not-so-famous, the blacks, the browns, the whites. It affects all of us.

Let me take this opportunity, since we have some of our colleagues here